



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR SUHAIL AL-SAHLI
1210 A NASA ROAD 1
HOUSTON TEXAS 77058

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-08-1629-01

MFDR Date Received

February 15, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This letter is to inform you that we are filing a Medical Dispute on [Injured Employee] requesting payment from the Insurance Carrier for the total amount of \$4,672.96 of the period of May 2004 – July 2004. We have appealed to collect these charges from the insurance carrier, but the carrier has failed to provide us with proper explanation for not paying for these services. These are office visits and they are not required pre-authorization. Also, manipulation was provided to help the patient's condition."

Amount in Dispute: \$4,672.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The hearing officer concluded (a) that disability from the injury extended from 7-12-0 [sic] through 12/25/03 and (b) that no disability existed after 12/25/03 through the present (3/14/06). The hearing officer ordered Texas Mutual to pay benefits consistent with the decision. (Exhibit). Texas Mutual understands this to mean that treatment from 5/3/04 through 7/8/04 occurred during the period in which there was no disability. And since there was no disability then the payment of benefits for the disputed dates would be \$00.00. For this reason Texas Mutual believes no payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 3, 2004 to July 9, 2004	Office Visits, Physical Therapy, Chiropractic Manipulative Treatment	\$4,672.96	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.308 sets out the procedures for resolving medical necessity disputes.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated June 23, 2004, June 24, 2004, June 29, 2004, July 1, 2004, July 12, 2004, July 19, 2004, July 22, 2004, August 2, 2004, August 4, 2004, August 5, 2004, August 6, 2004, August 10, 2004, and August 20, 2004

- YE – The carrier is disputing the liability of the claim or compensability of the injury. This has not been determined final through adjudication.

Explanation of benefits dated May 3, 2007 for disputed date of service May 3, 2004

- CAC W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- CAC 47 – This (These) diagnosis (es) is (are) not covered, missing, or are invalid.
- CAC 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- CAC 57 – Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
- 246 – The treatment/service has been determined to be unrelated to the extent of injury; final adjudication has not taken place.
- 247 – Evidence does not support the need for the duration, intensity and/or services billed.
- 255 – Based on the available information, this charge does not appear to be applicable in this case.
- 891 – The insurance company is reducing or denying payment after reconsideration.

Explanation of benefits dated May 3, 2007 for disputed date of service May 4, 2004

- CAC W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- CAC 16 – Claim/service lacks information which is needed for adjudication, additional information is supplied using remittance advice remarks codes whenever appropriate.
- CAC 47 – This (These) diagnosis (es) is (are) not covered, missing, or are invalid.
- CAC 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- CAC 57 – Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
- 207 – Need valid Texas Fee Guideline code.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 246 – The treatment/service has been determined to be unrelated to the extent of injury; final adjudication has not taken place.
- 247 – Evidence does not support the need for the duration, intensity and/or services billed.
- 660 – Reviewed in accordance with CMS policies on length of session, medical necessity for unusually length of time was not documented.
- 891 – The insurance company is reducing or denying payment after reconsideration.

Explanation of benefits dated May 3, 2007 for disputed date of service May 5, 2004, May 6, 2004, May 11, 2004, May 13, 2004, May 19, 2004, May 21, 2004, May 24, 2004, June 3, 2004, June 7, 2004, June 9, 2004, July 2, 2004, July 6, 2004, .

- CAC W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- CAC 47 – This (These) diagnosis (es) is (are) not covered, missing, or are invalid.
- CAC 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- CAC 97 – Payment is included in the allowance for another service/procedure.
- 246 – The treatment/service has been determined to be unrelated to the extent of injury; final adjudication has not taken place.
- 247 – Evidence does not support the need for the duration, intensity and/or services billed.
- 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.
- 891 – The insurance company is reducing or denying payment after reconsideration.

Explanation of benefits dated May 3, 2007 for disputed date of service May 10, 2004.

- CAC W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- CAC 16 – Claim/service lacks information which is needed for adjudication, additional information is supplied using remittance advice remarks codes whenever appropriate.
- CAC 47 – This (These) diagnosis (es) is (are) not covered, missing, or are invalid.
- CAC 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- CAC 97 – Payment is included in the allowance for another service/procedure.
- 207 – Need valid Texas Fee Guideline code.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 246 – The treatment/service has been determined to be unrelated to the extent of injury; final adjudication

has not taken place.

- 247 – Evidence does not support the need for the duration, intensity and/or services billed.
- 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.
- 891 – The insurance company is reducing or denying payment after reconsideration.

Explanation of benefits dated May 3, 2007 for disputed date of service May 12, 2004.

- CAC W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- CAC 16 – Claim/service lacks information which is needed for adjudication, additional information is supplied using remittance advice remarks codes whenever appropriate.
- CAC 47 – This (These) diagnosis (es) is (are) not covered, missing, or are invalid.
- CAC 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 246 – The treatment/service has been determined to be unrelated to the extent of injury; final adjudication has not taken place.
- 247 – Evidence does not support the need for the duration, intensity and/or services billed.
- 891 – The insurance company is reducing or denying payment after reconsideration.

Explanation of benefits dated May 3, 2007 for disputed date of service May 25, 2004.

- CAC D19 – Claim/service lacks physician/operative or other supporting documentation.
- CAC W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- CAC 47 – This (These) diagnosis (es) is (are) not covered, missing, or are invalid.
- CAC 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- CAC 97 – Payment is included in the allowance for another service/procedure.
- 246 – The treatment/service has been determined to be unrelated to the extent of injury; final adjudication has not taken place.
- 247 – Evidence does not support the need for the duration, intensity and/or services billed.
- 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.
- 819 – Please validate the report by providing the physician's signature on the report.
- 891 – The insurance company is reducing or denying payment after reconsideration.

Explanation of benefits dated May 3, 2007 for disputed date of service June 4, 2004, June 25, 2004, June 26, 2004, June 28, 2004, July 8, 2004.

- CAC W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- CAC 47 – This (These) diagnosis (es) is (are) not covered, missing, or are invalid.
- CAC 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- CAC 57 – Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
- CAC 97 – Payment is included in the allowance for another service/procedure.
- 246 – The treatment/service has been determined to be unrelated to the extent of injury; final adjudication has not taken place.
- 247 – Evidence does not support the need for the duration, intensity and/or services billed.
- 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.
- 891 – The insurance company is reducing or denying payment after reconsideration.

Explanation of benefits dated May 3, 2007 for disputed date of service June 14, 2004, June 18, 2004, June 21, 2004, June 23, 2004,

- CAC W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- CAC 47 – This (These) diagnosis (es) is (are) not covered, missing, or are invalid.
- CAC 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- CAC 57 – Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
- 246 – The treatment/service has been determined to be unrelated to the extent of injury; final adjudication has not taken place.
- 247 – Evidence does not support the need for the duration, intensity and/or services billed.
- 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.
- 891 – The insurance company is reducing or denying payment after reconsideration.

Explanation of benefits dated May 3, 2007 for disputed date of service June 30, 2004

- CAC W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- CAC 47 – This (These) diagnosis (es) is (are) not covered, missing, or are invalid.

- CAC 50 – These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.
- 246 – The treatment/service has been determined to be unrelated to the extent of injury; final adjudication has not taken place.
- 247 – Evidence does not support the need for the duration, intensity and/or services billed.
- 891 – The insurance company is reducing or denying payment after reconsideration.

Explanation of benefits dated May 3, 2007 for disputed date of service July 9, 2004

- CAC W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- CAC 47 – This (These) diagnosis (es) is (are) not covered, missing, or are invalid.
- CAC 50 – These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.
- CAC 57 – Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day’s supply.
- CAC 97 – Payment is included in the allowance for another service/procedure.
- 246 – The treatment/service has been determined to be unrelated to the extent of injury; final adjudication has not taken place.
- 247 – Evidence does not support the need for the duration, intensity and/or services billed.
- 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.
- 856 – Physical medicine and rehabilitation services may not be reported in conjunction with an E/M code performed on the same day.
- 891 – The insurance company is reducing or denying payment after reconsideration.

Issues

1. Was the issue of medical necessity for the services provided appropriately raised by the respondent?
2. Did the requestor bill for treatment of a compensable body area?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier raised the issue of medical necessity after the filing of the Medical Fee Dispute Resolution. Per 28 Texas Administrative Code §133.307(j)(2) “the response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.” Since the issue of medical necessity was raised after the MFDR was filed it will not be considered.
2. A Decision and Order signed on March 29, 2007 but effective on March 14, 2006 indicates that the injured employee compensable injury does not extend to include disc herniation at L3-4.
3. Review of the submitted documentation finds that services rendered were for the treatment of a non-compensable body area. As a result, the healthcare provider is not entitled to reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.